STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045201	A. Building B. Wing	05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chapel Woods Health and Rehabilitation	1440 East Church Warren, AR 71671

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and facility policy review, the facility failed to ensure a cognitively impaired resident was not left outside alone, unsupervised, and after hours for 1 (Resident #1) of 1 sampled resident reviewed for neglect. It was determined the facility's non-compliance with one or more requirements of participation had caused, or was likely to cause, serious injury, harm, impairment, or death to residents. The Immediate Jeopardy (IJ) was related to State Operations Manual, Appendix PP, 483.12 (Freedom from Abuse, Neglect, and Exploitation) at a scope and severity of J. The IJ began on 05/04/2025 around 5:45 PM when Resident #1 was left outside, alone and unsupervised, in the courtyard of the secured unit. The Administrator, Director of Nursing, and Nurse Consultant were notified of the IJ on 05/09/2025 at 8:54 AM. A plan of removal was requested. The removal plan was accepted by the State Survey Agency on 05/09/2025 at 6:36 PM. The immediacy of the IJ was removed on 05/09/2025 at 6:36 PM. The findings are: Review of an Office of Long-Term Care (OLTC) Incident and Accident [I&A] report with a discovery date of 05/5/2025 indicated that on 05/04/2025 at approximately 5:15 PM, Resident #1 requested to sit in the courtyard, located outside of the dining room on the secured unit, to get some sun. The resident was noticed missing on 05/05/2025 at 4:19 AM and was located on 05/05/2025 at 5:21 AM sitting outside in the courtyard. On 05/05/2025 at 10:45 PM, Resident #1 was interviewed and reported going outside after supper to sit. Resident #1 reported trying to come back in but could not because the door was locked. Resident #1 reported knocking hard on the door all night long and sitting wherever possible to stay warm because it was cold that night. A nursing general note dated 05/05/2025 at 5:21 AM indicated the Director of Nursing (DON) located Resident #1 sitting in a chair outside of the dining room on the patio with jacket zipped up and head covered. Review of an online weather service ' s historical data revealed the low temperature the morning of the incident, 5/5/2025, was 47 degrees Fahrenheit. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the Medical Diagnosis portion of Resident #1 ' s electronic health record revealed the resident was admitted to the facility on [DATE] with diagnoses of schizophrenia and psychotic disorder with hallucinations. Review of an annual Minimum Data Set with an Assessment Reference Date of 04/30/2025 revealed a brief interview for mental status score of 12, which indicates moderate cognitive impairment. The MDS also indicated Resident #1 required supervision/touch assistance with toileting and personal hygiene, shower/bathe self, chair/bed-to-chair transfer, toilet and tub/shower transfer. Review of the Care Plan Report, dated as revised 04/30/2025, revealed Resident #1 could benefit from placement in the secured neighborhood due to the need for a safe environment and special programming with an intervention of providing opportunity for the resident to experience growth, connectedness, meaning, and joy by participating in the life of the neighborhood. Resident #1 was an elopement risk/wanderer with an intervention of supervision in courtyard. On 05/05/2025 at 11:04 AM, Certified Nursing Assistant (CNA) #1 was interviewed over the telephone and stated that on the evening of 05/04/025, she opened the door to the courtyard so the residents could go outside after supper. She stated between 5:00 PM and 5:30 PM, the residents came back inside, and she did not see Resident #1 seated in the resident's usual seating area and she assumed Resident #1 had come back inside so she closed the door. CNA #1 stated she did not check the resident's room or anywhere else on the secured unit for the resident because the resident was in and out of the bathroom frequently and she thought the resident was in the bathroom when she made rounds. CNA #1 stated staff were supposed to round every two hours but that does not always happen. She stated she did not realize the resident was not in the room prior to leaving her shift at 11:00 PM because the resident frequently used the bathroom and when the resident was not seen in the room, she usually assumed the resident was in the bathroom. On 05/08/2025 at 1:32 PM, CNA #3 was interviewed by telephone and stated she came to work on 05/04/2025 around 10:50 PM and made rounds a little after 12 AM but could not give an exact time. CNA #3 stated when she looked in Resident #1 ' s room, she saw the bathroom light on and assumed the resident was in the bathroom but did not go in and check. She stated around 4:20 AM, she went to Resident #1's room to get the resident up and realized the resident was not there when she turned the light on. CNA #3 stated she notified the nurse [LPN #4], and staff began looking for the resident. She stated the DON was working that night up front and LPN #4 called and requested the DON come back to the secured unit. CNA #3 stated the DON located Resident #1 outside in the courtyard and brought the resident inside. CNA #3 stated she was sure the resident was cold but was unsure of what the temperature was the night of 05/04/2025. She stated staff were supposed to make rounds on the residents every 2 hours, but sometimes staff do not do that. On 05/08/2025 at 2:51 PM, the DON was interviewed and stated she was working the front of the facility, halls A and B, the night of the incident. At around 5:15 AM she was passing medications, and CNA #6 asked if the DON knew a resident was missing and she stated no. The DON immediately locked her cart and went to the unit. When she got to the unit she was told Resident #1 was missing. The DON stated she immediately started looking room to room while talking to the staff asking questions and asked when the last time Resident #1 was seen. Both the 7 AM to 7 PM nurse and 11 PM to 7 AM aide stated they had not seen Resident #1 during their shift. She stated she immediately called the day nurse [LPN #5] to see when the last time she saw the resident. LPN #5 stated it was around 5:30 PM after she had given the resident's medications and sat in the courtyard with the resident. The DON stated that while she was on the phone with LPN #5, she went to the dining room and courtyard door. The DON (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	opened the door, and the resident was sitting on the bench to the left of the door with a jacket on, zipped all the way up and face covered. The immediate jeopardy was removed on 05/09/2025 at 6:36 PM when the following plan of removal was implemented by the facility: Immediate interventions: 1. Resident was immediately brought into building and taken to his room where he was toileted, and clothing changed. 2. APN was contacted. She stated she would not be in the facility today so requested that facility schedule a tele-med visit. 3. Body Audit was completed on [Resident #1] with no negative findings. 4. Family notified, 5. Tele-med visit completed with new orders received_. 6. Abuse in-service began on Abuse and Neglect. 7. Body Audits completed on all residents on the secured unit with no negative findings. 8. The nurse [LPN #4] and CNA's [CNA #1, #2 and #3] were all placed on administrative leave. 9. Administrator/DON/designee will round the secure neighborhood 3 times per day, at least 1 time on each shift, to ensure that all residents are present in the confines of the building and safe. These rounds will begin on 5/9/25 and will be documented on a facility designed rounding calendar. 10. Beginning 3:00 p.m., 5/9/25, Administrator/designee will round the smoking area courtyard at least 1 time every 2 hours to ensure that wandering residents have not made their way outside, until security system with Wanderguard sensor automatic magnetic locks are installed. Action to Prevent Similar Incident: 1. Facility will ensure residents residing on the secure neighborhood will not be allowed to be in either facility courtyard unattended. D.O.N/Designee will train secured unit staff on this change beginning 5/5/25. No employee will be allowed to work the neighborhood until training is completed by 05-09-2025. 2. DON/Designee will train all nursing staff on the importance of making rounds at shift change to make sure all residents are accounted for. Trainings were begun on 5/5/25. Beginning at 12 noon on 5/9/25, no nursing staff will be allowed to work before being trained by DON/Designee and training will be completed by 05-09-25. 3. DON/Designee will train all LPNs/RNs [Registered Nurses] on the importance of completing midnight census with visual check of each and every resident. Training began on 5/5/25. Beginning at 12 noon on 5/9/25, no nurses will be allowed to work before being trained by DON/Designee on 05-09-25. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	4. Train all CNAS on the importance of completing 2-hour rounds and visualizing every resident even if they toilet independently. Training was begun on 5/5/25 by the DON. Beginning noon on 5/9/25, no aides will be allowed to work before being trained by DON/Designee and training will be completed by 05-09-25. By 1:00 p.m. on 5/9/25, a task was set up in the EMR (electronic medical record) system for aides to document 2-hour rounds. CNAs and nurses were trained by the DON/designee on the completion of this task on 5/9/25. The completion of this task will be verified by the charge nurse assigned to each work area at the end of the shift, starting at the end of evening shift on 5/9/25. 5. DON/Designee will train all staff on the elopement policy, including when resident is not located immediately within the facility, check the courtyards. Training began on 5/5/25 and training will be completed by 05-09-25. Beginning 12 noon on 519125, no employees will be allowed to work who have not been trained by 05-09-25. 6. From the time this QAA document was established on 5/5/2025, no employee has been allowed to work on the secure neighborhood until trained on the points above, with special emphasis on point #1. And no employee will be allowed to work on the secure neighborhood until they have been trained. All corrections were completed on 05/09/2025. Onsite Verification: The IJ was removed on 05/12/2025 at 2:30 PM after this surveyor performed an onsite verification that the removal plan had been implemented as follows: Immediate interventions: 1. Review of the reportable dated 05/05/2025 revealed Resident #1 was located outside the building at 5:21 AM and was brought inside, toileted and clothing changed. 2. Review of the progress notes revealed a nursing general note dated 05/05/2025 at 5:21 AM which indicated APN notified with no new orders. Plan for tele-med later in the morning. 3. Review of body audit dated 05/05/2025 indicated no negative findings. 4. This surveyor spoke with Resident #1's responsible party by telephone on 05/12/25 at 9:43 AM and she stated she was notified the morning of 05/05/2025. 5. Review of an Access Medical Note dated 05/05/2025 at 10:57 AM by APRN, revealed visit was conducted via tele-med with interactive audio and visual capabilities and was necessary due to resident was outside last night. 6. Review of the reportable dated 05/05/2025 included a training dated 5/5/25 conducted by the DON with a topic of abuse/neglect. 7. Review of the reportable revealed body audits on residents on the secured unit with no negative findings. 8. Review of the reportable dated 05/05/2025 revealed in the steps taken four staff members were suspended pending the outcome of investigation: [LPN#4, CNA #2, CNA #1, CNA #3]. 9. Review of sheets provided by the DON revealed a licensed nurse (LPN or RN) signed a document (continued on next page)

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